DIMA Questions and Answers
Supplement to December 19, 2003 DIMA Instructions

Contracts: Correction

The Q&As attached to the December 19, 2003, DIMA instructions state that any M+C organizations re-entering a previously reduced service area will be required to amend the existing contract at Attachment D to include the new counties they will serve (see DIMA Instructions Q&A #9 under "ACRP"). This statement is incorrect. M+C organizations that re-enter a service area reduced on January 1, 2004, will not be required to make any amendments to their contracts.

ACRP

1. **Q: The DIMA instructions say that HPMS will be available for uploading ACRPs beginning January 26. Can CMS make this an earlier date?**

   A: Yes. HPMS will be available for uploading beginning January 20, 2004.

2. **Q: Section 1 of the DIMA instructions (Item 3) addresses the option to update direct medical cost assumptions and projections from the previous ACR to the extent these additional costs would help to stabilize or enhance the M+CO's provider network. Does this include projected utilization spikes, such as the influenza epidemic?**

   A: Yes, the updated direct medical cost assumptions and projections could include utilization spikes such as those being caused by the flu epidemic. However, if an M+C organization chooses to exercise this option, it should review and make changes to all appropriate assumptions and projections, not just those related to the flu epidemic.

3. **Q: Under percentage of premium contracts, increases in the M+C revenue pass directly through to the providers and may not result in directly enhancing access or provider stabilization. Does this conform to DIMA requirements?**

   A: To the extent that provider contracts actually call for percentage of premium (POP) and documentation is available to substantiate that, and then it is the case that where an M+CO passes additional DIMA revenue on to such providers that such pass-through would conform with DIMA statutory requirements related to "stabilizing or enhancing beneficiary access to providers." This is true as long as such "stabilization/enhancement" does not result in increased beneficiary premiums, increased beneficiary cost sharing, or reduced benefits.

4. **Q: If an M+CO chooses to reduce beneficiary premiums, the changes made cannot have a value greater than the dollars received under DIMA. Is the value of changes prescribed by CMS? For example, if 80% of a $50 member premium flows through to the medical group, and the impact to the plan is actually $10. Is the removal of this premium a $50 change or a $10 change?**

A: M+COs are required to account for how the DIMA payment increase was used in the cover letter. This amount cannot exceed 100% of your payment increase (pre-DIMA APR vs. post-DIMA APR). However, if you eliminate a $50 member premium as described above, then the impact, for ACR purposes, is $50.

5. **Q: How does an M+CO reduce the premium or copay in plan that includes both individual and employer group members? What must the M+C plan do to the employer group's premium or copay, given that the premiums and copays are negotiated between the M+C plan and the employer groups?**

   A: The answer depends on the type of plan and situation:

   - If an M+CO offers an "800" EGHP-only plan, the M+CO can put all DIMA dollars into a stabilization fund and then withdraw them in 2005. Full withdrawal would be possible in 2005 under a BIPA 617 waiver of 42 CFR 422.312(c)(5) rules.

   - If an M+CO offers a plan in which both enrollees and EGHP members are enrolled, the M+CO can use all DIMA dollars solely to reduce premiums for all. In cases where the EGHP is paying premiums on behalf of its members, this would create minimal disruption to EGHP members.

   - If an M+CO offers a plan in which both enrollees and EGHP members are enrolled, and premium reduction is either not an option or would create disruption, we will allow a BIPA 617 waiver that is called "actuarial swapping." See section 130 of Chapter 8 of the Medicare Managed Care Manual - http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp - on how to request this type of waiver. In the case that an M+CO uses an "actuarial swapping" waiver, we will allow the M+CO to put "weighted" dollars in a stabilization fund for employer group members and leave their benefits, premiums and cost-sharing the same as filed and approved in the original 2004 ACR. At the same time the M+CO can also increase benefits, reduce cost-sharing, premiums and etc. for individual members of the same plan. When 2005 ACRPs are filed, the M+CO will be required to create an "800" plan for the employer group members of these "actuarial swapped" plans and enroll all EGHP members from the "actuarial swapped" plan in 2004. The M+CO will then be permitted to withdraw in 2005 from the stabilization fund of the "actuarial swapped" plan solely for the EGHP "800" plan members.
     An M+CO that wishes to use a BIPA 617 actuarial swapping waiver must contact Nancy Kitchen (410-786-7637 or nkitchen@cms.hhs.gov) to obtain approval of the waiver before submitting its ACRP.

6. **Q: Must ACRs for employer-sponsored plans be refiled? How does a plan show improvement to benefits in a plan that does not, in effect, exist (i.e., no member has these benefits)?**

   A: Yes, they must be re-filed. (See Question #5 of this section for more detailed information.)

7. **Q: If a employer group plan has a generic only drug benefit and the M+CO wants to add a drug benefit that now covers brand drugs, what must the M+CO do to employer group rates or benefits in 2004? If we can show CMS that all groups have a brand drug benefit as of March 1, are we in compliance?**

   A: See our response to Question #5 of this section.

8. **Q: The DIMA may create additional administrative costs for health plans. May these be reflected in the DIMA ACR?**

   A: According to the DIMA ACR Instructions, M+COs cannot increase administrative costs unless the increase has a significant and direct relationship to stabilizing or enhancing beneficiary access to providers or is directly related to enhanced benefits.

9. **Q: According to the DIMA Instruction Q&A's, M+C plans cannot reduce the cost sharing (or premium) for a mandatory benefit. It can only reduce cost sharing for Medicare covered or additional benefits. If a M+C plan's ACR (even under DIMA) is far above the APR, can the M+CO reduce cost sharing for a mandatory benefit?**

   A: DIMA dollars can be used to reduce premiums/cost-sharing for Medicare benefits, and/or to fund additional benefits. However, they cannot be used to reduce premiums/cost-sharing for mandatory supplemental benefits. If there is a specific case in which an M+CO finds it is impossible or impractical to apply DIMA dollars to one of the permitted purposes (vis., reduce premiums/cost-sharing for Medicare benefits, enhance benefits, etc.), please bring the situation to our attention prior to submitting your DIMA ACRP.

10. **Q: Is eliminating or reducing a deductible in a drug plan considered "enhancing a benefit" or "reducing cost sharing" under your rules about not being able to reduce cost sharing in a mandatory benefit?**

    A: Deductibles are considered cost sharing. A reduction in cost sharing for a mandatory supplemental benefit is not a permitted use of DIMA dollars. It would be permissible to reduce cost sharing related to an additional benefit as a means of expending DIMA dollars.

11. **Q: If an M+C plan has a drug deductible, can the M+CO eliminate the drug deductible in January and February.**

    A: No. The premiums, cost sharing, and benefits in a current CMS-approved ACR must be collected/offered during January and February.

12. **Q: If a plan wants to reduce office visit copays using the additional DIMA dollars, but cannot implement this change until June 2004, can it show a 7-month (instead of 12-month) actuarial value in the ACR and implement this change in June 2004 rather than as of March 2004?**

A: Additional benefits and/or premium/copay reductions (etc.) must be in place for March 1, 2004.

13. Q: Can M+COs add a new plan and submit MYBEs during the DIMA season?

A: Effective December 19, 2003, CMS stopped accepting new mid-year benefit enhancement proposals or new mid-year plan proposals until March 1,2004. Currently, CMS is reviewing new mid-year plan proposals & MYBE proposals that were submitted prior to December 19, 2003 and will continue to do so until January 8, 2004. Where possible, CMS will work with M+C organizations to complete outstanding ACRP submissions prior to the start of the DIMA process. However, if an ACRP submission remains outstanding as of January 9, 2004, CMS will work with the M+C organization to determine whether those changes can be incorporated into the DIMA ACRP submission. CMS will resume accepting ACRPS for new plans on March 1, 2004 (or later) - this is the case regardless of whether or not an M+CO plans to offer an exclusive Medicare endorsed prescription drug discount card with that new plan.

14. Q: Can M+C organizations with approved CY 2004 M+C plans that are re-entering a previously reduced service area restore all or part of their previous service area during the DIMA 2004 ACRP season?

A: Yes. M+C organizations must send CMS written notification of intent to re-enter all or part of their CY 2003 service area that was non-renewed for January 1, 2004, using a model letter. Because ACRs are due January 30, M+C organizations are strongly encouraged to submit this letter by January 23, 2004. The model letter is in Attachment 2. This letter must also include a Certification of Network Adequacy (Attachment 3). (Attachments 2 & 3 can be found in the Instructions for the DIMA 2004 ACRP Season.)

15. Q: Question 21 of the Q&As that came with the DIMA instructions talks about the new rates reflecting catch up payments. Does this mean that if someone is enrolled in March, but there are catch up payments for January and February, the M+CO receives less money?

A: M+COs will be paid the higher DIMA rate retroactively for members they had in January and February 2004.

16. Q: In Section 7 of the DIMA instructions, the calculation for the drug card premium requires M+COs to subtract administrative costs from $30, and prohibits M+COs from charging more than that total. Is that because the administrative cost is already built into the combination of CMS revenue and monthly member premium, so in effect the M+CO would be getting paid twice?

A: Administration costs related to the drug card are subtracted from $30 because $30 is the maximum charge allowed for enrollment in a Medicare endorsed drug card. To the extent

that some of the administration costs for drug card enrollment have already been claimed in the ACR, they cannot be claimed again through an enrollment fee.

17. **Q: According to the DIMA instructions, M+C plans cannot use DIMA dollars to enhance a Mandatory Supplemental benefit. Would an M+CO be permitted to change the type of a benefit, as it is now shown in the PBP approved by CMS, to an Additional benefit and then be permitted to allocate DIMA dollars towards that benefit, and perhaps add a closed formulary Brand benefit (as a second tier), also as an additional benefit?**

    A: Yes, an M+C organization can convert a benefit from either the optional supplemental or the mandatory supplemental benefit category to the additional benefit category. Also, they can move the premium associated with it and allocate DIMA funding towards that benefit.

18. **Q: Can M+COs reduce their margin (Additional revenue) in their DIMA ACR Proposal as compared to the ACR approved by CMS?**

    A: Yes, Additional revenues in DIMA-related ACRs can be decreased from your previous, CMS-approved ACR if the decrease is directly related to enhanced benefits in the revised PBP. For example, assume that the DIMA increase is $15 PMPM, which converts to $18 PMPM over the 10-month period. If a plan reduces premium by $20 and identifies $18 as DIMA money and $2 as a voluntary reduction in additional revenue (not changing trends or any other assumptions), this would be permissible. However, it is not permissible to decrease additional revenue if the enhanced benefits are not directly related to DIMA.

19. **Q: How can a plan add or enhance a non-Medicare benefit with cost sharing under DIMA?**

    A: An M+CO can add or enhance a non-Medicare benefit by adding a new additional benefit at no additional cost to the plan enrollee or by adding a new additional benefit with cost sharing.

20. **Q: Are M+COs allowed to reduce the member premiums beyond the dollars offered through DIMA?**

    A: M+COs are allowed to reduce the member premiums beyond the dollars offered through DIMA. A reduction in member premiums can exceed 100% of your payment increase (pre-DIMA APR vs. post-DIMA APR). ***(See our response to question 18, above.)*** Additionally, M+COs have the option to update direct medical cost assumptions and projections that were previously reported in their CMS-approved ACRs for CY 2004. If this update results in an excess amount, this excess amount can be used to enhance benefits beyond DIMA. In the cover letter, M+COs need to clearly distinguish the benefit enhancements due to DIMA and those attributable to updated direct medical cost assumptions and projections. Accordingly, M+COs should only report information related to DIMA funding when responding to the questions in HMPS.

21. Q: What benefits can be moved from Mandatory Supplemental to Additional category?

A: All or part of a Mandatory Supplemental benefit can be reclassified to an additional benefit category and DIMA funding can be used to enhance that additional benefit.

22. Q: What makes an "Additional Benefit" vs. a Mandatory Supplemental Benefit?

A: **Additional Benefits** include direct health care services not otherwise covered by Medicare and indirect benefits (i.e., reduction in enrollee premiums for Part B of Medicare and reductions in premiums or cost sharing for Medicare-covered services). M+C organizations identify additional benefits and must offer them to Medicare beneficiaries at no additional premium. ***Additional benefits are funded by the adjusted excess amount, while mandatory supplemental benefits are funded solely by beneficiary premium and cost sharing.***

<u>"Special Needs" Plans</u>

1. **Q: Do the proposals for a special needs plan need to be submitted on January 31 with the new ACR filing?**

   A: The statute allows specialized MA plans for special needs individuals "upon enactment." See section 231 of DIMA. The statute also allows for up to one year to write regulations. At this time we can only accept or process applications for this type of plan related to Medicaid and Institutionalized individuals. Otherwise, as indicated in the DIMA ACR Instructions, ACRs for "new" plans cannot be submitted during the DIMA ACR season (January 9, 2004, through March 1, 2004). These new "special needs" plans are independent of the DIMA ACR resubmission process and cannot be submitted during the DIMA ACR season.

2. **Q: Does the special needs plan need to focus on a single population, or for example, can we offer one plan that covers both dual eligibles and institutional populations?**

   A: They can be "mixed" - see §1859(f) of the Social Security Act. However, until regulations are written, special needs populations are limited to Institutionalized and Medicaid individuals.

3. **Q: Are special needs plans eligible for any alternative funding, for example the increased revenue for nursing home certifiable enrollees currently received by the Social HMOs?**

   A: No, they are not.

4. **Q: Will the special needs plans be required to meet all of the same provider access standards as a regular M+C plan, e.g., be available county-wide? Or, in the case of an institutional population, can the program be limited to the skilled nursing facilities that are part of the network?**

A: CMS is working internally to provide more guidance on this issue.

5. **Q: Do special needs plans need to be marketed in all M+C SBs and other member materials, as we have to do today when we offer multiple plans in a market/county?**

   A: We are not aware of any requirement that an M+CO include all plans in an SB (i.e., the M+CO can develop several SBs, one for each plan it offers). Similar rules will apply to specialty plans.

6. **Q: Will M+COs receive any additional information regarding the expected content of the proposals to be submitted?**

   A: Yes. CMS will be issuing additional information on the required content of the proposals.

7. **Q: When will CMS be providing a new application for "special needs" plans?**

   A: CMS will not be developing a new application for "special needs" plans. As the DIMA instructions state, any current M+CO interested in offering a <u>new</u> "special needs" plan must submit its request to CMS Central Office with a copy to the appropriate CMS Regional Office. When submitting a formal request, the organization must submit the following information as part of its proposal:

   1. Description of the proposed plan.
   2. Explanation of how the contracted provider network(s) will meet access and availability standards.
   3. Explanation of what types of providers will serve the plan(s) (e.g., Home Health).
   4. Proposed effective date for the new plan.

   CMS will not accept proposals for "special needs" plans during the DIMA ACR season (January 9, 2004 through March 1, 2004). CMS will begin accepting proposals on March 1, 2004 (or later).

<u>Stabilization Fund</u>

1. **Q: If an M+C organization chooses to use a stabilization fund (or has funds remaining from BIPA), how can it avoid having funds forfeited to the Medicare Trust Funds?**

   A: If an M+C organization wishes to avoid having its funds forfeited to the Trust Funds, it should ensure that the amount remaining in its stabilization fund for 2005 is no greater than the amount the organization would be permitted to use for 2005 additional benefits under the ordinary withdrawal rules in 42 CFR 422.312(c)(5). We are only permitted to waive the limits on the amount that can be deposited or withdrawn from a stabilization fund during the DIMA 2004 ACR season. If an organization chooses to deposit to a stabilization fund all or part of the DIMA dollars, keep in mind that those monies may only be used in 2005, and only

to the extent that the amounts do not exceed the limits on the amount that can be withdrawn in a given year. [Note that 617 BIPA waivers will be available to "800"-series EGHP plans that will permit "accelerated" or full withdrawal from a stabilization fund in 2005.]

2. **Q: If an M+CO filed an employer group ACR prior to DIMA, and now files a DIMA ACR that puts all the additional DIMA dollars into the stabilization fund for this employer group plan, can the M+CO file an employer group waiver in 2005 to make sure it can pull all the money out of the stabilization fund in 2005 for the employer group plan?**

   A: Yes.

3. **Q: An M+CO cannot withdraw and contribute to a stabilization fund in the same year. If an M+CO is confident that it can take all the money out in 2005, can it stop the 2004 withdrawal in the DIMA ACR and begin a contribution to the fund through the DIMA ACRs? Does stopping a stabilization withdrawal constitute an "explanation" for using the additional DIMA dollars? How do we account in the ACRs for the fact that stoppage of the withdrawal in the fund will not occur until March 2004 rather than January 2004?**

   A: Stabilization fund deposits and withdrawals can be reversed during the DIMA ACR season. Stopping a stabilization fund withdrawal might constitute an "explanation" for using a portion of DIMA dollars. Since stabilization fund withdrawals can only be used to fund additional benefits, and to the extent that DIMA dollars are used in the place of stabilization fund dollars, this might constitute a permissible use of DIMA dollars. Finally, you do not need to separately account in the ACR for the fact that stoppage of the withdrawal from a stabilization fund will not occur until March 2004, rather than January 2004. All ACR submissions and computations are based on a calendar year.

4. **Q: Can you explain what the stabilization fund should be used for if an M+CO chooses to use one?**

   A: Stabilization fund dollars may only be used to provide additional benefits – see §1854(f)(2) and 42 CFR 422.312(c)(2). Additional benefits are defined at 42 CFR 422.2 as "…health care services not covered by Medicare, and reductions in premiums or cost-sharing for Medicare covered services…"

Marketing Material Review

1. **Q: Plans must notify members of benefit changes by March 8 (which cannot mention a Drug Discount Card until April 1) and send EOCs by April 1, 2004. Can the M+CO's intent on offering the Drug Discount Card be mentioned (with "pending federal approval") in the March DIMA mailing?**

   A: No, the M+CO may not mention the drug discount card in the March mailing. The law requires M+COs to notify members of the DIMA-related benefit/cost sharing changes within

3 weeks of ACR approval, which equates to March 8. At the same time, no company (M+CO or otherwise) may begin marketing the drug discount card until April.

2. **Q: Will CMS provide model EOC language for the Drug Discount Card?**

   A: Yes, we will provide model language shortly.

3. **Q: The DIMA instructions state that if a M+C plan does not enhance plan benefits or reduce the premium or cost sharing, then the March 8 notice to members is not necessary and instead, notification of the changes to Medicare coverage can be included in either the EOC cover letter or as an insert to the EOC. Will there be model language to describe the new Medicare coverage?**

   A: We do not plan to provide more model language to describe the Medicare coverage. M+COs can use the language in Section 9 of the DIMA instructions (see "Notification to members about changes in Medicare Coverage"). For more reference language on the religious non-medical health care institution (RNHCI) coverage, M+COs can also use the updated model language provided in Section 7 of the EOC (which can be found at http://www.cms.gov/healthplans/marketing/).

4. **Q: If a M+CO does not enhance plan benefits or reduce the premium or cost sharing, and did not mention the benefits affected by the new Medicare coverage in Section 3 of the plan's 2004 SB, then does this mean that there is no requirement to revise the 2004 SB to mention the new Medicare coverage and therefore, a M+CO would not be required to produce a new 2004 SB for the plan?**

   A: That is correct.

5. **Q: Section 9 stated that the model EOC has been updated to include the new Medicare coverage under DIMA. Is this updated model on the web?**

   A: The updated model can be found at http://www.cms.gov/healthplans/marketing/.

6. **Q: If an M+CO has already mailed its EOC to members, does the MCO need to mail an addendum to the EOC to describe the DIMA and Medicare changes, or is the March 9 notice sufficient notification?**

   A: The March 9 notice is sufficient notification. We recommend that you treat the March 9 notice as an addendum to the EOC and instruct members to file it with their EOC.

7. **Q: If an M+CO has already mailed its EOC to members, and does not have any changes to benefits, premiums, and/or cost sharing, is a newsletter notice sufficient for notification of the Medicare coverage changes?**

A: Yes, we would consider this to be sufficient notification. We recommend that you instruct members in the newsletter article to file the article with their EOC so they have all benefit information in one place.

8. **Q: The model letter in Attachment 5 of the DIMA instructions contains a sentence that all M+COs might not need to communicate to members (last paragraph, second sentence). Can this sentence be considered optional, i.e., if the M+CO follows the model without modification and does not include this sentence, can it still get a 10-day expedited marketing review?**

   A: Yes, this sentence can be considered optional. As an FYI, the optional sentence states "For help comparing your Medicare health plan choices or choosing a supplemental (Medigap) insurance policy, contact the [*insert specific State Health Insurance Assistance Program name*] at 1-800-[*XXX-XXXX*] and [*TTY/TDD number*] or visit the www.medicare.gov website."

9. **Q: The model letter in Attachment 5 of the DIMA instructions is written such that the M+CO must insert the actual member's name at the beginning of the letter. May M+COs instead insert "Dear Member" (or some other term for "member," such as "enrollee") and still obtain the 10-day marketing review?**

   A: Yes.

10. **Q: What is the time frame for marketing the drug discount card?**

    A: As the DIMA instructions state, all M+COs offering an Exclusive Discount Drug Card may begin marketing the card on April 1, 2004. Any M+CO offering a non-exclusive discount drug card may begin marketing the card on the same date that all other sponsors will be permitted to begin marketing their cards.

11. **Q: Do M+COs marketing a non-exclusive drug discount card need to mention the card in their EOC?**

    A: These M+COs will not be able to mention it in their EOC since the EOC must be mailed by April 1. Instead, the M+CO may notify members through an addendum to the EOC, but this is not required.

12. **Q: Is the March 9 date for mailing out the notices to members the date the notice must be mailed or the date it must be received by the members?**

    A: It is the date the notice must be mailed.

13. **Q: If an M+CO is only changing on benefit (such as reducing the premium) and did not mention the benefits affected by the DIMA Medicare coverage changes, must the M+CO modify the SB and mail it to all members?**

A: In this case, the M+CO would not need to mail a revised SB to all members. However, it would need to modify the SB (or create an addendum) for prospective enrollees.

Miscellaneous

1. **Q: Section 11 of the DIMA instructions state that the Medicare Medical Savings Account (MSA) portion of the M+C application will be added shortly. Has this been added?**

   A: Yes, the M+C application has been updated for MSAs. The application can be found at http://www.cms.gov/healthplans/applications/.

2. **Q: When will M+CO's receive their January and February catch-up payment? To whom should additional payment questions be forwarded?**

   A: M+CO's will receive their January and February catch-up payment as a part of their February payment. Additional payment questions should be forwarded to Marla Kilbourne (mkilbourne@cms.hhs.gov 410.786.7622) or Kim Miegel (kmiegel@cms.hhs.gov 410.786.3311).